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What Happened to Health-Care Reform?

Paul Boothe
Mary Carson

In this issue...

Access to health care and the sustainability of the system will remain problematic until governments and the public are willing to confront changes needed to bring the mismatch between the growth of costs and fiscal resources back into balance.

The Study in Brief

Public concern about access and government concern about the unsustainable growth of spending have prompted a number of high-profile commissions on health reform. This *Commentary* compares the recommendations of the Fyke, Mazankowski, Kirby, and Romanow reports, and evaluates the responses of governments in Saskatchewan, Alberta, and Ottawa.

Although all four reports make similar recommendations to improve delivery of core services, sharp differences emerge regarding fiscal sustainability, access, private sector involvement, coverage, and the role of the federal government. Kirby and Mazankowski directly address the problems of access and fiscal sustainability by recommending the establishment of access guarantees and strategies to generate additional revenues. Kirby and Mazankowski also favour some private sector delivery of publicly funded services, an approach that Romanow strongly rejects. In contrast to the provincial reports, Kirby and Romanow recommend extending coverage to catastrophic drugs and home care. All four reports recommend the creation of arm's-length agencies to oversee reform. Kirby and Romanow envision a substantially expanded role for the federal government.

Governments have made limited progress in responding to these recommendations. Saskatchewan consolidated health districts and established a Quality Council but did not convert small hospitals to primary care centres as the Fyke report recommended. In response to the Mazankowski report, Alberta increased health care premiums and the tobacco tax but declined to release a report regarding funding options, replaced the commitment to access guarantees with access standards, and rejected the establishment of an arm's-length panel charged with making funding recommendations. As a result of the 2003 First Ministers' Accord, the federal government tabled an eight-year funding commitment for health care renewal in the 2003 budget, an amount that will grow at a rate exceeding the projected growth of the economy and of federal revenue.

In responding, governments have failed to address the two key concerns that prompted the health reform reports: access and sustainability. Access and sustainability will remain problematic until governments and the public are willing to confront the difficult changes needed to bring the current mismatch between the growth of health care costs and fiscal resources back into balance.

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Canadians and their governments are worried about the state of the health care system. Yet, every day the system delivers a broader range and greater number of services, and by international standards, most indicators of the quality of Canadian health care are high and rising (OECD 2003). So what is the problem?

In fact, at the core of the concern are two problems: access and fiscal sustainability. For the average Canadian, access is the central concern — is the health care system able to provide the services I need when I need them? In its most recent survey of annual waiting lists, the Fraser Institute reports that the median time between referral by a general practitioner and an appointment with a specialist rose to 8.3 weeks in 2002/2003, from 3.7 weeks in 1993, while the median time between an appointment with a specialist and the beginning of treatment increased to 9.5 weeks from 5.6 weeks over the same period (Esmail and Walker 2003).[1] Moreover, individual Canadians are aware of these growing waiting times. In surveys by Alberta Health and Wellness of how easy or difficult it is to obtain needed health services, respondents who rated access as "easy" or "very easy" fell to 62 percent in 2002 from 74 percent in 1997 (Alberta 2002a). Yet the number of services provided is expanding rapidly — much faster than the growth of the population, even after adjusting for aging. For example, the number of magnetic resonance imaging (MRI) tests performed in Alberta in 2001 and 2002 rose 62 percent, to 19,937 from 12,276; at the same time, however, the number of patients waiting for an MRI rose 123 percent, to 15,718 from 7,053 (ibid., 4).

Governments are worried about the rapid growth of health spending relative to revenue. At first glance, it is not clear why. Fiscal sustainability requires that the growth rate of spending be at or below the growth rate of government revenue. Over the past 10 years, health spending by the provinces and territories has grown at an average annual rate of 4.2 percent, while combined federal and provincial government revenues have grown by an average of 4.1 percent — hardly an alarming divergence, although the gap has widened in the most recent five years, with the growth of health spending outpacing that of revenues by 7.1 percent, compared with 4.3 percent (Canada 2002a, 313).

Another way to look at fiscal sustainability is to focus on the share of the country's gross domestic product (GDP) that spending consumes. That share fell to 6.5 percent in 1996/1997 from 7.2 percent in fiscal year 1991/1992, then rose to 6.8 percent by 2001/2002. Boychuk (2002) suggests that for the past five years the

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1 The determination of accurate and comparable waiting times is hampered by the absence of a standardized definition of "waiting time" for a given procedure. The Western Canada Wait List Project, initiated in 1999, has made significant progress in developing protocols for defining wait times; these use indicators that are comparable across jurisdictions and include measures of urgency. Historical comparisons such as those reported by the Fraser Institute rely on less accurate information but are nevertheless valuable because of the scarcity of long-term comparisons. For information on the Western Canada Wait List Project, see web site: www.wcwl.org.

health system has simply been "catching up" after the reductions that accompanied provincial deficit elimination in the early 1990s. So why the concern?

Provincial and territorial governments are alarmed about health spending because its share of overall program spending has risen to 41 percent from 32 percent in the past 10 years, and it is now crowding out other important areas such as infrastructure, education, and social programs. The reason oft-cited share-of-GDP numbers do not sound the alarm is that 10 years ago most provinces (and the federal government) were running substantial deficits — on average equal to 15 percent of spending. Thus, 10 years ago, Canadians were actually paying for (as opposed to financing through borrowing) only 85 percent of the cost of health care. Adjust the numbers to reflect the growth in health spending that Canadians actually paid for, and the 10-year growth rate is not 4.2 percent, as noted above, but 5.6 percent; for the past five years, the growth rate rises to 8.2 percent from 7.1 percent. Such growth rates are substantially higher than those of government revenue.[2]

Governments have reacted to Canadians' concerns about access and their own about rising costs by commissioning a number of high-profile studies to examine the problems and to propose solutions. This *Commentary* focuses on four of those reports, commissioned by the provinces of Saskatchewan and Alberta, the Senate, and the federal government. All four were given similar mandates, and all reflect the themes of access and fiscal sustainability (Box 1).

In the next section, we compare the recommendations of the four reports and highlight areas of agreement and disagreement. Next, we look at government responses to these reports, and examine progress to date in implementing their recommendations. We conclude by evaluating governments' efforts to reform the Canadian health care system.

The Reports

The four reports we focus on are those of Saskatchewan's Fyke Commission (Saskatchewan 2001b), Alberta's Mazankowski Council (Alberta 2001), the Senate's Kirby Commission (Canada 2002b), and the federal government's Romanow Commission (Canada 2002a). We might have chosen the reports of other provincial governments, but focusing on those of Saskatchewan and Alberta enabled us to limit the scope of our investigation and to take advantage of our personal knowledge of health reform in those two jurisdictions.

Of course, it is difficult to summarize in one short paper four reports, each of which runs to hundreds of pages in length. Accordingly, we limit our summary to four key issues — fiscal sustainability, coverage, delivery, and governance — and highlight areas of agreement and disagreement among the four reports. (For a summary of the reports' recommendations under the four headings, see Appendix Tables A-1 through A-4.)

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2 See Robson (2001) for a discussion of the impact of aging on future health costs and a proposal to begin now to "pre-fund" some of those future expenditures.

Box 1: ***Mandates for Health Reform Studies Commissioned by Saskatchewan, Alberta, the Senate, and the Federal Government***

Saskatchewan (Fyke Commission)

1. To identify key challenges facing the people of Saskatchewan in reforming and improving Medicare...
2. To recommend an action plan for delivery of health services across Saskatchewan through a model that is sustainable and embodies the core values of Medicare...
3. To investigate and make recommendations to ensure the long-term stewardship of publicly funded, publicly administered Medicare. (Saskatchewan 2001b, 86-87.)

Alberta (Mazankowski Council)

"[R]eview Alberta's health system to ensure it meets Albertans' needs and is sustainable for the future" (Alberta 2001, 12).

The Senate (Kirby Commission)

"[Discover] what needs to be done to reform Canada's health care system and make it fiscally responsible" (Canada 2002b, xiii).

The Federal Government (Romanow Commission)

"[R]ecommend policies and measures respectful of jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system" (Canada 2002a, xi).

The Fyke Report

The Fyke report (Saskatchewan 2001b), released in April 2001, acknowledges that Saskatchewan's health system is fiscally unsustainable, but argues that improved efficiency and reduced demand for services from a healthier population could provide sufficient savings to restore a balance between resources and demand.[3] The report makes no explicit recommendations for expanding coverage beyond the services currently covered by the Saskatchewan Health Insurance Plan, but assigns to a proposed Quality Council the role of using evidence on effectiveness and cost to recommend what treatments should be covered as new technologies emerge.

Many of the report's recommendations concern the way health services should be delivered. For example, it advocates a substantial reduction in the number of health districts, and lays out a service plan that includes converting smaller hospitals to primary care centres and limiting the number of hospitals that provide specialized procedures in the interests of enhancing quality. Like the other three reports we consider, Fyke addresses health care delivery with recommendations to improve primary care, health promotion and disease and injury prevention, health information

3 The report reviews other options for bridging the gap between cost and revenue but makes no specific recommendations.

and information technology, human resources practices, and research. The report also includes specific recommendations for health delivery to aboriginal and remote communities.

Finally, the Fyke report does not look to the federal government to play a significant role in reforming Saskatchewan's health system. Rather, the report recommends the creation of a new provincial body, a Quality Council, with wide-ranging responsibilities for leading health reform through standards-setting for use and quality of service, performance monitoring and reporting, and evidence-based recommendations on coverage.

The Mazankowski Report

Like Fyke, the December 2001 report of the Mazankowski Council (Alberta 2001) recognizes that the provincial health system — in this case, Alberta's — is fiscally unsustainable. Unlike Fyke, however, it suggests that efficiencies alone would not be enough to restore the balance between resources and demand. The report predicts that even an efficient health system would grow faster than government revenue, leading to recommendations for increased revenue for health care and the use of evidence-based decisionmaking to determine which treatments should be publicly funded. To increase revenue, the Mazankowski report recommends raising health care premiums and tying them to the growth in health spending, permitting Regional Health Authorities (RHAs) to charge for selected services not covered by the *Canada Health Act*, and developing a new funding mechanism that uses co-payments or deductibles to create incentives for consumers to use the system responsibly.

Like the other three reports we summarize, Mazankowski calls for accelerated reform of health care delivery in the areas of primary care, health promotion and disease and injury prevention, health information and information technology, human resource practices, and health-related research. It recommends that RHAs be funded through multi-year contracts for delivery of services and that they should encourage internal competition for private delivery of publicly funded services where cost effective. The report also recommends the publication of waiting lists and the establishment of patient guarantees of timely access to key procedures.

The Mazankowski report's approach to coverage is based, in part, on affordability — that is, the principle that the most cost-effective treatments should be funded up to the overall limits of an affordable public health care system. The report recommends that a panel of experts be established to decide which broad categories of services should continue to be funded. The panel would also have an ongoing responsibility to establish an evaluation process to determine which new and existing treatments should be publicly funded.

Finally, like Saskatchewan's Fyke report, the Mazankowski report also does not see an expanded role for Ottawa or additional funding from it. Rather, the report recommends, in addition to the panel, the appointment of an individual who would both lead and monitor the progress of reform, and the establishment of a permanent outcomes commission that would report to the public regularly on the performance of the health care system.

The Kirby Report

The report of the Senate's Kirby Commission (Canada 2002b), delivered in October 2002, also proceeds from the premise that Canada's current health care system is not fiscally sustainable. To restore the system to a sustainable path, the report argues, it is necessary both to make the system more efficient and to increase resources. The report recommends that Ottawa contribute a fixed portion of an existing federal tax. Kirby suggests that 45 percent of the goods and services tax (GST) would be appropriate, thus ensuring that federal contributions grow with federal revenue. In addition, the report recommends that Ottawa spend about $5 billion and the provinces $1.1 billion to expand services. The report suggests that federal funding for expanded services could come from a new, income-based National Variable Health Care Premium, ranging from $185 per year for those in the lowest income tax bracket to $1,400 per year for those in the highest income tax bracket.

Kirby places a strong emphasis on reform of the primary health care system and increased attention to health promotion and disease and injury prevention, as well as other areas of service delivery noted in all the reports. It argues that responsibility for providing services should be largely devolved to regional health authorities, which should be funded on the basis of the services they provide. The Kirby report also backs some private sector delivery of publicly funded services to encourage competition.

Kirby argues that publicly funded health insurance be expanded significantly to include coverage of post-acute and palliative home care and catastrophic drug costs. The report also advocates the guarantee of timely access to key procedures, with government covering the cost of individuals receiving treatment in other jurisdictions if the guarantee is not met. Finally, the report also argues for the creation of a National Health Care Insurance Coverage Commission to advise government on which services should be publicly funded as new treatments and procedures are developed.

Unlike the two provincial reports, the Kirby report sees a marked expansion in the federal government's role in the health system. Not only would Ottawa fund a large portion of the recommended new services, but the report also calls for the appointment of a National Health Care Commissioner and National Health Care Council to lead and monitor the progress of reform.

The Romanow Report

The report of the federal government's Romanow Commission (Canada 2002a), released in November 2002, sent mixed signals on the issue of fiscal sustainability of the health system. Early on, the report argues that the system is "as sustainable as we want it to be" (p. xvi). Yet it also recommends that $6.5 billion in short-term funding be provided to "buy" change (p. 71) and that the federal contribution should be increased and grow at a rate that is faster than the growth of federal revenue (p. 70). The report rejects the use of co-payments or deductibles, arguing that Canadians are willing to pay higher taxes to fund health care if needed.

Like the other three reports, Romanow advocates improvements in service delivery, and makes special mention of improving access to services in rural areas

and aboriginal communities. It argues for better management and reporting of waiting lists, but rejects the notion of a guarantee of timely access. It is strongly opposed to private delivery of publicly funded health services (p. 9), and recommends the extension of health care insurance to cover catastrophic drugs, home care, and additional diagnostic procedures. The report devotes considerable attention to the issue of pharmaceuticals, recommending the establishment of a national body to approve drugs for public funding.

Finally, the Romanow report calls for a substantial increase in the role of the federal government. A key element of the report's recommendations is its proposal that a Health Council of Canada be established and given a wide-ranging mandate to lead reform and hold governments accountable for results. The council's responsibilities would include monitoring, assessing, and reporting on the performance of provincial health systems, evaluating new technologies and making recommendations regarding their delivery and funding, and helping to resolve disputes between the federal and provincial governments. The council would consist of representatives of the federal and provincial governments and the public, and health care experts.

The Reports Compared

One important issue on which the four reports diverge is fiscal sustainability. The Romanow report did not clearly address the issue; the other three acknowledge that the status quo is unsustainable, but differ on how to remedy the problem. Fyke believes that fiscal sustainability could be restored by making the health system more efficient, thereby reducing its rate of growth. Both Kirby and Mazankowski argue that improving efficiency and reducing the growth of costs is not enough — that more revenue is needed. Mazankowski alone highlights the need to change incentives for providers and consumers.

Kirby suggests that the increased revenue come from federal and provincial governments and be used, in part, to fund expanded coverage. Key to Kirby's recommendation is that Ottawa's contribution for existing services be tied to a growing tax base — the GST — and that funding for expanded coverage come from a new tax — a variable health care premium. It makes no mention of how federal funding for expanded coverage would grow or how the provinces would fund their portion of the cost of such coverage.

A key assumption of the Mazankowski report is that even an efficient health system is likely to grow faster than government revenue. The report thus argues that health care premiums be tied to the growth of the health system, and that a new mechanism be developed for funding health care that would contain incentives for responsible use by consumers and providers.

Although Romanow does not clearly address the issue of fiscal sustainability, the report advocates greater efficiency in order to reduce the growth of costs and, similar to Fyke and Kirby, recommends short-term funding to "buy" change. In addition, Romanow recommends additional ongoing federal funding that would grow at a rate faster than federal revenue, though it is silent as to how Ottawa should generate this revenue — whether, for example, through reducing expenditures in other areas or raising taxes — or how provincial governments

should deal with the funding pressures they already face, let alone those that would be added as a result of expanded coverage.

All four reports focus considerable attention on core aspects of delivery, with Fyke providing an explicit blueprint for service delivery. All four emphasize the need for primary care reform, health promotion and prevention of disease and injury, improved information and information technology, better human resource practices, and support for health research. Fyke, Kirby, and Romanow make special mention of the need to improve health delivery to aboriginal, rural, and remote communities.

Another key area of divergence among the reports is whether timely access to required health services should be *guaranteed*, with Mazankowski and Kirby arguing for such a guarantee, and Fyke and Romanow preferring to talk about *targets*. Mazankowski and Kirby are, in addition, more open than are Fyke and Romanow to the idea of the private delivery of publicly funded services. Both reports encourage developments in this area to enhance competition, while Romanow strongly discourages increased private sector involvement.

On the issue of health coverage, both Kirby and Romanow recommend that it be extended to include catastrophic drug costs and home care, while neither Fyke nor Mazankowski would expand services. All four reports discuss mechanisms for determining whether new treatments should be publicly funded. Fyke and Mazankowski make it clear that new treatments should be evaluated for both their medical and cost effectiveness; Mazankowski goes even farther in placing special emphasis on affordability as a key criterion.

Each of the reports sees new roles for arm's-length bodies that would lead reform, monitor and report on progress and quality, and help make decisions about future coverage. Perhaps not surprisingly, both the federal Kirby and Romanow reports see a substantially expanded role for Ottawa, despite their recommendation that the provinces continue to fund the large majority of health costs.

Governments' Responses to the Reports

Each of the four reports naturally prompted a response from the government to which it was directed. In this section, we look at those responses, and reviews the progress the relevant governments have made to date in implementing the reports' recommendations. (For a summary of government actions to date, see Appendix Tables A-1 through A-4.)

Saskatchewan and the Fyke Report

Saskatchewan Premier Lorne Calvert, responded cautiously to the Fyke report, and committed only to "listening" to the reaction of the public (Saskatchewan 2001a). The government invited Mr. Fyke to meet with the Legislative Assembly in a special "committee of the whole" to present his commission's report and respond to questions. Following the meeting, the government established an all-party committee to collect and summarize public responses and report to the Assembly.

In its official response — the Action Plan released in December 2001 (Saskatchewan 2001c) and the subsequent Primary Care Action Plan of June 2002 (Saskatchewan 2002b) -- the Saskatchewan government accepted the general direction of the Fyke report, with an important exception: It rejected a key recommendation that smaller hospitals be converted into primary care centres, preferring to leave those decisions in the hands of the new regional health authorities.

The Fyke report argues that efficiencies are needed to restore balance between costs and resources. It reviews other measures to ensure fiscal sustainability, but does not recommend any of them. The government's Action Plan was similarly silent on other solutions, beyond "working with the federal government to ensure adequate funding of medicare" (Saskatchewan 2001c, 74).

The government marked the first anniversary of the Action Plan with a press release reporting on progress in implementing the plan (Saskatchewan 2002a). This included consolidation of health districts into 12 regional health authorities plus a special northern region, the establishment of the Quality Council, work on measuring waiting times for selected surgical procedures, and funding of research and a number of health-promotion and disease-prevention programs. Human resources initiatives were also under way as well as a new primary care group in Estevan. In August 2003, the government announced the establishment of a 24-hour health care advice telephone line.

Alberta and the Mazankowski Report

Alberta received the Mazankowski Council's report with great enthusiasm and promises of early action. The premier made the report the focus of his annual televised speech, which occurred in late January 2002. The next day, the Alberta government accepted all of the report's 44 recommendations, committing to raise health care premiums[4] and tobacco taxes in the spring budget as a first step, and establishing a number of teams or committees to study various aspects of implementation:

- a three-person implementation team mandated to work with the Department of Health and Wellness to develop a detailed implementation plan and monitor and publicly report on progress;
- a task force of Assembly members to study options for health care funding;
- a committee on collaboration and innovation to facilitate communication among health regions and to study multi-year contracts for funding regional health authorities;
- a panel to recommend a process to determine which health services should be publicly funded, and
- a committee to examine changes to the *Health Professions Act*.

The implementation team and the health department presented a detailed plan to the minister in spring 2002 with progress reports in January and September 2003.

4 In fact, the Mazankowski report recommended that health care insurance premiums be raised and set as a share of total health spending.

In the 2003 updates (Alberta 2003b, 2003c), the team noted mixed results, particularly in the area of fiscal sustainability.

The MLA task force studying funding options reported to the minister in September 2002, but the government took no action and declined to release the report.

The committee examining multi-year contracts also reported in September 2002 (Alberta 2002b), with the government accepting it in large measure and releasing it to the public. To date, however, the government has made no information available regarding implementation. Interestingly, given the attention it received when the government accepted it, the Mazankowski report's recommendation of *guaranteed* 90-day access to selected procedures was quietly dropped and replaced with simple "access standards" for selected procedures in the implementation team's May 2003 update.

The panel examining which health care services should be publicly funded attracted controversy from the outset — health reform opponents reacted in alarm when, at one point, the premier referred to it as the "delisting" committee. The panel reported to the minister in March 2003, and the report was released to the public in July (Alberta 2003d). The government rejected both the panel's recommendation to change the funding of selected non-*Canada Health Act* services (including chiropractic and optometry) and its proposal of a permanent, non-partisan body to examine and make funding recommendations based on effectiveness and affordability. The government issued its own progress report on health reform in March 2003 (Alberta 2003a) that noted advances in the areas of health promotion, health information and information technology and primary care.

The First Ministers and the Kirby and Romanow Reports

In February 2003, the First Ministers convened in Ottawa to discuss their collective response to the Kirby and Romanow reports. The result was the 2003 First Ministers' Accord on Health Care Renewal. In the Accord, the federal government agreed to establish a Health Reform Fund to finance improvements in primary care and coverage for home care and catastrophic drugs. In addition, it agreed to increase its contribution to provincial health system costs through a new Canadian Health Transfer and to increase funding for public health measures, diagnostic/medical equipment, health information and information technology, improved human resource practices, research, and aboriginal health. For their part, the provinces agreed to spend targeted money in the designated areas, report on results, and participate in the establishment of a National Health Council with a mandate to "monitor and make annual reports to the public on the implementation of the Accord, particularly its accountability and transparency provisions."[5]

Ottawa began implementing its commitments flowing from the Health Accord in the budget it tabled in February 2003. The budget laid out a firm health funding

5 See www.hc-sc.gc.ca/english/hca2003/accord.html. Quebec declined to participate in the National Health Council, but agreed to collaborate, with the nature of the collaboration to be determined.

commitment until fiscal year 2007/2008 and proposed a schedule of transfers until 2010/2011. The budget projected funding to grow over the eight-year period at an average annual rate of almost 6.5 percent — significantly faster than the projected growth of either the economy or federal revenue. Moreover, the budget identified no new taxes or other revenue sources to finance this increased expenditure. Over the four fiscal years beginning 2003/2004, Ottawa committed $16 billion to the Health Reform Fund to support primary care as well as expanded coverage of home care and catastrophic drugs. It also committed additional funds to support provinces' purchases of diagnostic and medical equipment, development of information technology, health and human resources, and research.

Since the February 2003 federal budget was tabled, federal and provincial health ministers have been negotiating the details of the various agreements. One area of disagreement that has attracted attention is the mandate for the National Health Council. In the First Ministers' Accord, the council is restricted to reporting — quite a modest role compared with the sweeping responsibilities Romanow, and to a lesser extent Kirby, envisioned for such a body. Some premiers have complained, however, that the federal government, in its plans for the council, is trying to restore the broader mandate Romanow proposed, despite the wording and intent of the First Ministers' Accord. The premiers themselves are divided on the issue, and have called for its resolution after the new prime minister is installed.

What Happened to Health Reform?

As we noted earlier, the demand for health reform originates from concern about access on the part of the public and fiscal sustainability on the part of government. In light of these concerns, what are we to make of the four reports' prescriptions and the responses by governments? And what lessons can we draw from this round of health reform that may be useful in formulating and implementing health policy in the future?

Fiscal Sustainability

A significant barrier to successful health reform has been the continued misunderstanding of the fiscal sustainability problem. It is not that, at any point in time, Canadians are spending too much on health care; rather, it is that the cost of the health system is rising significantly faster than available resources in the economy.[6] As the Fyke report describes so well:

> It is important to remember that health costs are increasing at a rate faster than general government revenues. Should current trends continue, future health expenditures will exceed available resources by a significant and substantial amount. The historical practice of increasing health expenditures at the expense of other important public services is not a feasible, practical or advisable approach. (Saskatchewan 2001b, 103.)

6 In fact, Canada probably is spending too much public money on health care, since the health status of the population almost certainly could be improved by moving resources from the acute care system to health promotion and disease prevention and to other social spending that affects the underlying determinants of health.

Box 2: ***The Simple Arithmetic of Fiscal Sustainability***

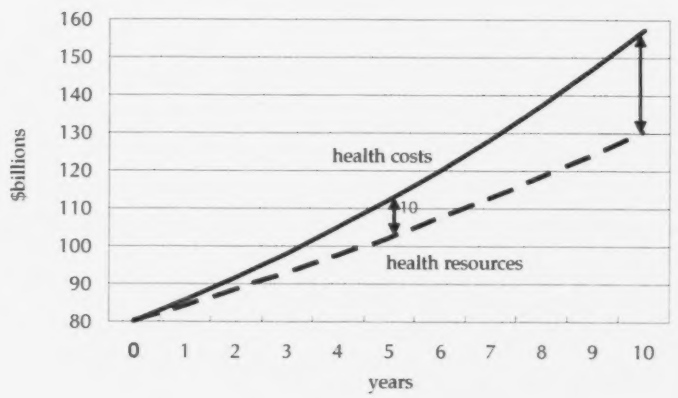
A simple example may be useful to illustrate the fiscal sustainability problem. The numbers we use are rough approximations of the current Canadian reality. We begin with four assumptions:

1. Government (federal and provincial) revenues grow at 5 percent per year.
2. The cost of the current health system grows at 7 percent per year.
3. The current cost of the public health system is $80 billion.
4. Federal cash transfers for health are currently $10 billion and grow sustainably at the rate of federal revenue.

As the figure below shows, the impact of the mismatch between the growth of health costs and the growth in government revenue is striking. In five years' time, it reaches $10 billion per year, or about $330 per year for every Canadian. The gap can be filled by program cuts in other areas, such as education or infrastructure, or by continually rising taxes — in this case, by about $1,300 per year for a family of four.

Because the proportion of federal funding for health care is small (14 percent), changes in the level of funding from the federal government have relatively little effect. Even if the federal government increases its contribution to an unsustainable 7 percent per year, the gap in five years' time is reduced only to $300 per year for every Canadian. Clearly, sustainable reform must restore a balance between the growth of costs and and that of revenues.

The Health Sustainability Gap



Missing from the public discussion of fiscal sustainability is the realization that the issue is not whether the health system has "enough" money, but the ongoing mismatch between the growth of health costs and the growth of fiscal resources (as measured by government revenue, if one is considering the publicly funded portion of health spending) (Box 2). As long as this mismatch exists, governments will accommodate it by transferring to health ever more resources from other areas of their budgets, raising taxes, or borrowing more — or some combination of the three.

To restore fiscal balance to the publicly funded health system, it is necessary to slow the growth of costs or increase the growth of sustainable revenues available to the system, or both. All four of the reports that we examine in this paper focus

considerable attention on strategies to make the health system more efficient. It is unclear, however, if these potential efficiencies would effectively create ongoing cost reductions. Further, it is unclear, given economic and political incentives currently embedded in the health system, whether these cost reductions could be captured by governments or simply used to expand health services in other areas.

Efforts to achieve a sustained reduction in the growth of costs can be divided into bottom-up and top-down approaches. In a bottom-up approach, incentives — such as consumer co-payments and deductibles and fundholding by providers — are intended to encourage consumers and providers to use the health system responsibly. Although strongly opposed in some quarters in Canada, such mechanisms are used in European countries with some success (see, for example, Okma 2001; Canada 2002b, appendix 4.1; Hjertqvist 2002).

Under a top-down approach, a constraint, such as placing a maximum on the share of program spending devoted to health care, could, if enforced, result in the choice of more cost-effective treatments. It is an open question, however, whether it would be politically feasible to ration care to satisfy an affordability constraint, given the pressure that interest groups could bring to bear on health ministers and governments more generally. Politically, a top-down approach would also require that excess demand for services be accommodated by allowing the private purchase and delivery of services that were not publicly funded. One can easily imagine the outcry if, for reasons of cost effectiveness, one patient group received public funding for a procedure that was proven to be particularly beneficial for them, but other groups were denied coverage for the same procedure. Communicating such a distinction to the public would be a challenge, even though the public is already paying for higher standards of care than public health insurance covers — such as for private hospital rooms and plastic, rather than plaster, casts.

If governments attempted to improve efficiency by reorganizing the delivery of services without changing incentives, even a more efficient public system might well, as the Mazankowski report notes, grow faster than government revenue. Yet, for reasons of fairness, Canadians might want to retain the current approach of universal first-dollar coverage.[7] At the same time, it is undesirable to continue to crowd out other important public services, such as education, social assistance, and infrastructure.

Meeting these competing demands might require the development of new sources of dedicated health care revenue that grow faster than general revenue. Such revenue sources might also provide opportunities to improve incentives, as several authors have proposed (see, for example, Aba, Goodman, and Mintz 2002; and Reuber and Poschmann 2002).[8]

The Four Reports and Fiscal Sustainability

All four of the reports we cover in this paper detail ways to make the health care system more efficient, and all but Fyke recommend that funding for health care be

7 In fact, the need for a universal first-dollar coverage system to ensure "fairness" is highly debatable. Fairness would dictate that no one be denied care because of low income, not that care be provided to everyone regardless of income.

8 Press reports indicate that Alberta's MLA Task Force on Health Care Funding and Revenue Generation also recommended such incentives.

increased. On how to raise additional revenue, however, the reports vary considerably. Kirby clearly recommends dedicating a share of the GST to existing health services and introducing a new tax for expanded services. Mazankowski recommends that health premiums be raised and tied to spending. Romanow recommends more funding but does not identify a funding source — presumably, resources would come from projected future federal surpluses, unspecified spending in other areas, or forgone tax reductions.[9]

Surprisingly, Romanow explicitly recommends that federal contributions to health care grow at an unsustainable 1.25 times the growth of the economy. Of the four reports, only Mazankowski recommends an approach that attempts to incorporate incentives for consumers and providers. In addition to raising health care insurance premiums and tying them directly to health spending (thereby contributing to sustainability), Mazankowski recommends developing a new approach that would both raise additional revenue and create incentives for responsible use.

Government Responses and Fiscal Sustainability

As for the response of governments to the fiscal sustainability issue, Saskatchewan and Alberta have accomplished little. Both have taken some measures to improve the efficiency of the health system, and Alberta raised health care premiums in its 2002 budget, but decided against tying premiums to health care costs. No action has been taken on additional revenue measures or changing incentives.

In response to the Romanow report, the federal government, as noted earlier, committed in its 2003 budget to increase transfers at a rate significantly faster than general revenue for the next eight fiscal years. Presumably, such growth will crowd out federal program spending in other areas, increase debt, or make tax reduction less likely.

Predictably, the new federal funds may actually have had the effect of discouraging provincial initiatives on fiscal sustainability by temporarily removing the necessity to take action. Indeed, for both Alberta and Saskatchewan, the gap between the growth of health spending and the growth of revenue (including federal transfers) over fiscal year 2002/2003 (actual) and 2003/2004 (budget projections) has widened. In Saskatchewan, revenue is projected to grow an average of 1.4 percent annually, while health spending is projected to rise 7.2 percent annually. In Alberta, revenue is projected to remain flat over the two years while health spending is projected to grow at an average of 7.8 percent annually. Given the two provinces' political cycles, the window in which their governments are willing to implement unpopular reforms has closed. Indeed, in its past two budgets, Saskatchewan chose to return to deficit financing rather than confront the fiscal sustainability issue.

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9 The problem with this approach is that it precludes any opportunity to compare additional health spending with alternative uses of the funds — spending in other areas, debt reduction that permits resources to be shifted from interest payments to programs, or tax reductions.

Coverage

Interestingly, both the federal Kirby and Romanow reports recommend significant expansions of coverage, but the provincial Fyke and Mazankowski reports do not — perhaps because the provincial commissions were more sensitive to fiscal sustainability concerns, given the greater threat to provincial budgets. Kirby and Romanow recommend expanded public insurance for home care and catastrophic drugs. Romanow and Mazankowski argue for improved access to diagnostic imaging, particularly MRI.[10] Mazankowski and Kirby recommend that timely access be guaranteed for certain procedures, yet despite the fact that timely access is Canadians' primary concern about the health system, Romanow rejects the notion.

In responding to the coverage issue, the First Ministers agreed that, in return for new federal funding, the provinces would provide "first dollar" coverage of a limited "basket" of short-term home care and "reasonable access" to catastrophic drug coverage. Provincial health ministers are currently negotiating with their federal counterpart just how much additional coverage the new federal funding can buy.

Alberta, although it accepted the Mazankowski report's recommendation, has quietly abandoned plans to guarantee access to selected procedures in favour of simple access targets, which already exist, for a number of procedures. In addition, Alberta rejected the recommendations of its Expert Advisory Panel on Publicly Funded Services on changes to the coverage of chiropractic and optometric care as well as a proposed process to recommend which new services should be publicly funded.

Delivery

All four reports contain recommendations to improve primary care, promotion of health and prevention of illness and injury, health information and information technology, human resources practices, and health research. Kirby, Romanow, and Fyke also include measures for specific populations. These areas for proposed change had been on the agenda of the 2000 First Ministers' meeting or had been the focus of ongoing reform efforts before the four reports were issued. Both Mazankowski and Kirby recommend that the funding of health delivery be changed to correspond to services rather than factors such as wages and salaries, and capital. Both reports also encourage private and not-for-profit provision of publicly funded services in order to benefit from competition in the health care system. Fyke lays out a detailed plan for the consolidation of complex procedures in major Saskatchewan centres in the interests of promoting quality.

Alberta and Saskatchewan responded to their reports' recommendations by increasing funding in a number of existing areas of health programming. Some of this funding is related to increased federal support, a significant proportion of which pre-dated the 2002 Health Accord. Both provinces have now made a 24-hour telephone health line available, and both have achieved some progress in telehealth,

10 It is ironic, given the emphasis on basing funding and delivery decisions on scientific evidence, that the two federal reports offer little evidence that more diagnostic imaging is the most cost-effective way to spend additional health dollars.

electronic health records, and information technology. Reform of primary care, however, has been slow, and is largely still in the pilot stage in both provinces, although Alberta recently proposed a new primary care funding plan to physicians.[11]

Saskatchewan has consolidated health districts into a smaller number of regional health authorities, but has failed to convert small rural hospitals into primary care centres as Fyke recommends. Alberta has made little progress in paying for outputs rather than inputs beyond what already existed for "province-wide" services — complex procedures available largely in Edmonton and Calgary.

Governance

All four reports recommend the establishment of new relationships among the participants in the health system. Fyke calls for a Quality Council, while Mazankowski recommends that a single individual be appointed to lead reform and report progress to the public. Mazankowski also calls for an expert panel to make recommendations on what health services should be publicly funded. Both Kirby and Romanow recommend the establishment of a National Health Council with a sweeping mandate to lead reform and report publicly on progress.

Governments' responses to these recommendations have been mixed. Saskatchewan has established a Quality Council, but it is still too early to know what responsibilities it will assume or what its ultimate impact will be on health reform. Alberta has established a Health Reform Implementation Team, but it has had little noticeable effect so far on the outcome of health reform in the province. The province rejected the idea of a permanent expert advisory panel to make recommendations about public funding of health services.

In response to the two federal reports, the First Ministers agreed, as part of the 2003 Health Accord, to establish a National Health Council, but gave it a much narrower mandate than either Kirby or Romanow suggest. As noted earlier, some premiers have complained that Ottawa is attempting to establish a council with what they claim to be an expanded mandate, which, they fear, will render the council simply an advocate for additional health spending.

Lessons Learned

What lessons can be learned from the latest round of health reform in Canada? First, we must acknowledge the bright spots: 24-hour health advice lines and primary care pilot projects, and additional funding for health information and information technology, health promotion and disease and injury prevention, human resources management, and health research. But these advances should more rightly be considered part of the ongoing evolution of the health system rather than fundamental reform. Funding for expanded coverage will have little impact in Saskatchewan or Alberta, where income-tested home care and catastrophic drug coverage are already well established.

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11 See www.gov.ab.ca/acn/200311/15457.html.

It is clear, however, that the latest round of health reform has failed to address the two major concerns that prompted it: access and fiscal sustainability. Simply adding more funding to areas such as diagnostic imaging has been tried in the past and has failed to reduce waiting lists. Governments' understanding of this fact has led them, despite their rhetoric regarding accountability in the health sector, to reject guarantees of timely access to services. Unsustainable growth in federal contributions to finance health care — and, in Saskatchewan, deficit financing — can hardly be considered effective solutions to the problem of fiscal sustainability. Lacking fiscal sustainability in the health system, credible action on access is impossible.

Three of the reports we examined either fail to understand the dynamic nature of the fiscal sustainability problem (as in the cases of Kirby and Romanow) or simply fail to address it (Fyke). Mazankowski proposes a workable solution to the problem, but the Alberta government was unwilling to discuss the issue publicly. Without new federal funding that temporarily removed the urgency of the fiscal problem, the provinces might have been forced to pursue health reform more aggressively. Fiscal reform is in abeyance in both Alberta and Saskatchewan, and we should not expect the governments of those two provinces to take any unpopular decisions in the near future.

Two lessons emerge from the latest round of health reform. First, it is critical that governments and the public understand the underlying problem of fiscal sustainability. The Romanow report, for example, confuses both public and politicians by stating that the health system is as "sustainable" as Canadians want, and misses an opportunity to lay out clearly the facts on fiscal sustainability. Provincial politicians should not pretend that simply adding more federal money will provide a lasting solution to the fiscal problems of the health system.

The second lesson is that, notwithstanding the political rhetoric, it is not possible to "buy" reform. An excellent example of the failure of this strategy is the attempt to pay to reduce waiting times. Rather, the incentives consumers and providers face must change if their behaviour is to change, otherwise more money will simply buy Canadians more of what they currently have — including more of the same problems.

As a final word, the federal response contained in the First Ministers' Health Accord and the 2003 budget commits a large portion of future federal surpluses (if they materialize) to health care, and is clearly unsustainable. Probably the most important thing a future prime minister could do to encourage a sustainable health system is to resist any further provincial demands for federal transfers for health care. It may be that, until voters are faced with a clear choice — more health care versus less education or other important public services — lasting health reform will remain beyond our grasp.

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Table A-1: *Recommendations by Health Care Reform Reports on Fiscal Sustainability and Government Responses to Date*

Item	Report Recommendations				Government Response
	Fyke April 2001	**Mazankowski** December 2001	**Kirby** October 2002	**Romanow** November 2002	
Increase revenue	None	Increase and tie health premiums to health spending; institute deductible or co-insurance payment mechanism	Dedicate specific share of GST to health; introduce new income-adjusted health premium	Increase revenue, but source not specified	SK: None AB: MLA Task Force developed funding strategy — report not released; tobacco tax increase, April 2002; one-time premium increase, April 2003 CAN: None
Efficiencies	Reform primary health care; stay healthy; improve information technology and human resources strategies	Same as Fyke	Same as Fyke	Same as Fyke	SK: One primary care centre established; 24-hour health line and telehealth programs established AB: Primary care pilots; 24-hour health line established CAN: Eight electronic health record pilots through Canada Health Infoway
Limit coverage	None	Fund new services only if affordable	None	None	SK: None AB: Expert Advisory Panel made coverage recommendations; report rejected. CAN: None

Table A-2: *Recommendations by Health Care Reform Reports on Coverage and Government Responses to Date*

Item	Report Recommendations				Government Response
	Fyke April 2001	**Mazankowski** December 2001	**Kirby** October 2002	**Romanow** November 2002	
Home care	None	None	Cover post-acute home care; extend EI benefits for palliative home care	Introduce targeted 2-year home care transfer; cover palliative and informal caregiving	SK: None AB: None CAN: Portion of Health Reform Fund (HRF) ($16 billion over 5 years in 2003/2004 budget) allocated for home care and palliative care; funding to extend EI benefits for palliative care
Catastrophic drug coverage	None	None	Legislate coverage for catastrophic drugs	Introduce targeted 2-year catastrophic drug transfer	SK: None AB: None CAN: Portion of HRF for catastrophic drugs
Formulary	None	Develop national strategy to contain costs	Develop national drug formulary	Introduce national drug agency to develop national formulary	SK: None AB: None CAN: Funding for the Common Drug Review housed with Canadian Coordinating Office for Health Technology Assessment
Access guarantees	No guarantees	Guarantee access for specific services	Legislate Health Care Guarantee remuneration to obtain services elsewhere if needs not met locally	None, but introduce targeted 2-year transfer to diagnostic services fund to improve access	SK: Historical waiting times posted online, January 2003 AB: Initial support by for access guarantees, later downgraded to access targets; waiting times posted online, October 2003 CAN: Continued direct federal transfers through the Diagnostic/Medical Equipment Fund

Table A-3: *Recommendations by Health Care Reform Reports on Delivery and Government Responses to Date*

Item	Report Recommendations				Government Response
	Fyke April 2001	**Mazankowski** December 2001	**Kirby** October 2002	**Romanow** November 2002	
Primary care reform	Convert small hospitals to primary care centres; start 24-hour telephone advice line	Expand number of primary care models	Increase funding for provincial initiatives	Introduce targeted 2-year Primary Health Care transfer to fast-track reform; establish Health Council to monitor progress	SK: No hospital closures; one primary care centre established; 24-hour health telephone line established AB: Pilot primary care programs; 24-hour health telephone line established CAN: Portion of HRF for primary health reform
Health promotion and disease and injury prevention	Primary care centres should focus on staying well and management of chronic disease	Key issues: education, child poverty, tobacco use; use 10-year targets, public education, incentives to stay healthy	Establish National Chronic Disease Prevention Strategy; integrate public health and health promotion across Canada	Establish Canada Health Infoway to provide credible information; develop National Immunization Strategy	SK: Continue community programs: early childhood, diabetes, fitness AB: Tobacco reduction (April 2002) and diabetes strategies (May 2003) with 10-year goals; public education campaign; coverage for new vaccines; community programs devolved to RHAs CAN: $45 million over 5 years to increase activity in children; portion of HRF to develop national immunization strategy
Health information and IT	Develop electronic health record (EHR)	Develop EHR	Establish Canada Health Infoway to develop national EHR	Work with provinces to develop EHR; ensure interoperability	SK: Canada Health Infoway pilot AB: EHR pilot CAN: Additional $600 million over 3 years for Canada Health Infoway, including EHR pilots

Table A-3 - continued

Item	Report Recommendations				Government Response
	Fyke April 2001	**Mazankowski** December 2001	**Kirby** October 2002	**Romanow** November 2002	
Human resources (HR) practices	HR needs should be coordinated provincially; introduce contracts for specialist services; increase educational funding	Introduce incentives for attracting, retaining health providers; implement alternate payment plans for physicians; provide stable training funding	Create permanent national HR committee; transfer funds directly to educational institutions; recruit aboriginal workers; license international graduates; review scope of practice	Health Council should develop plan for HR issues; develop strategies to be less dependent on foreign-trained workers	SK: Recruitment and retention pilots; student bursaries tied to service contracts; funding to recruit and train aboriginal nurses; retraining and upgrading funding AB: Pilot to recruit foreign professionals; bursaries for aboriginal providers; continuation of existing contracts for province-wide services CAN: $90 million over 5 years to support HR planning and coordination
Regionalization and hospital restructuring	Reduce the number of health districts from 39 to between 9 and 11; consolidate hospital services	Fund RHAs through multi-year service-based contracts	Devolve decisionmaking to RHAs; introduce service-based funding for hospitals	None	SK: 39 health districts restructured to 12 RHAs plus one special northern region; services restricted to specific hospitals; small hospitals converted to health centres and devolved to RHAs; no hospital closures AB: Committee on Innovation and Collaboration clarified mandates for government and RHAs; 16 existing RHAs consolidated to 9 CAN: None
Private delivery of publicly funded services	None	Introduce where cost effective	Encourage public/private hospital partnerships; clarify *Canada Health Act* does not preclude private delivery	Hospitals and clinics should be public and not-for-profit	SK: None AB: Continuation of privately operated diagnostic imaging laboratories, day surgery clinics, workers compensation hospitals CAN: None

Table A-4: *Recommendations by Health Care Reform Reports on Governance and Government Responses to Date*

Item	Report Recommendations				Government Response	
	Fyke April 2001	**Mazankowski** December 2001	**Kirby** October 2002	**Romanow** November 2002		
Reform leadership and reporting	Quality Council should lead reform and report on progress	Appoint individual to lead health reform and report on progress	National Health Care Commissioner should lead reform and report on progress	Health Council should provide leadership and report on progress; National Drug Agency should report on utilization and outcomes	SK: AB: CAN:	None Health Reform Implementation Team reports on health reform progress Health Council mandate source of controversy among provinces
Quality and standards	Quality Council should determine standards, monitor quality, and report to the public	Introduce Outcomes Commission	Introduce National Health Care Council; provide funding for Canadian Institute for Health Information (CIHI) and Canadian Council of Health Services Accreditation	Health Council of Canada should determine indicators, monitor and assess progress, and measure performance	SK: AB: CAN:	Quality Council established May 2003, first report available Health Services Utilization and Outcomes Commission to monitor quality, safety, utilization and patient satisfaction Canadian Patient Safety Institute to reduce medical errors; $95 million over 4 years for CIHI in partnership with Statistics Canada to report health indicators
Evidence-based coverage decisions	Quality Council should evaluate new technologies and make funding recommendations	Expert Panel should evaluate new and existing procedures and make coverage decisions	Committee on Public Health Care Insurance Coverage should make coverage decisions	Health Council should disseminate health technologies, pharmaceuticals evaluations; National Drug Agency should establish a national formulary	SK: AB: CAN:	Quality Council established May 2003 Expert Panel established May 2002 for limited term, report rejected $45 million over 5 years for Canadian Coordinating Office for Health Technology Assessment, announced February 2003

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